Department of Medical Assistance Services
600 East Broad Street
Suite 1300
Richmond, VA 23219

https://dmas.virginia.gov
MEDICAID MEMO

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Changes to the Prior Authorization Process for Treatment Foster Care Case Management – Effective March 1, 2007

The purpose of this memorandum is to provide information on changes to the Treatment Foster Care Case Management (TFC-CM) prior authorization (PA) process with Virginia Medicaid's PA contractor, Keystone Peer Review Organization (KePRO). This information will assist providers in expediting the review process. As indicated in the January 31, 2007 DMAS memo, there are changes, effective March 1, 2007, to the reimbursement rate for TFC-CM. The following changes to the PA process became effective on March 1, 2007. An interactive WebEx training that provides clarification to the TFC-CM changes, including changes to the PA process, will be held March 22, 2007 from 2pm to 3:30pm. Providers may access this web-cast by logging on to www.genesys.com and click on **participant** in the upper right corner. The **Moderator's Meeting Number is 9240330.** You may also access this web-cast **via telephone by dialing 1-866-462-0164. The meeting number is 9240330.**

Changes to the KePRO Prior Authorization (PA) Fax Form (DMAS-364)

Attached to this memo is the revised DMAS 364 (Treatment Foster Care-Case Management Preauthorization Request Form) and instructions for TFC-CM request for services. The revised DMAS 364 will be for TFC-CM exclusively. In box number 2 of the DMAS 364, the provider must include the locality code. The locality code is needed to reflect the locality that has fiscal responsibility for the Medicaid recipient. The code is a 3-digit number. A list of locality codes can be found in the DMAS 364 fax form instructions. The locality will be responsible for providing the correct locality name to the provider. The responsible locality is the same locality that would be indicated on the Reimbursement Rate Certification. As of March 1, 2007, the Reimbursement Rate Certification is no longer needed for the TFC-CM PA process.

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There are other changes noted on the revised DMAS 364 fax form to help expedite the review process. In place of some of the previous narrative requirements and attachments, the new form has new check box elements. The form has been reduced from a two-page form to a single page. Please pay careful attention to these changes, as they will assure quick turnaround to your request. Attachments are no longer required. These changes will streamline both facsimile and iEXCHANGE submissions. If submitting requests by fax, please review the revised DMAS 364 and instruction sheet attached to this memo.

Changes to the Billing Process for TFC-CM

For claims with dates of service on March 1, 2007 or later, the reimbursement rate certification will no longer be required for submission with the claim. The claim can be submitted electronically, and will be paid at the new, monthly, Medicaid rate of $326.50, as long as the claim passes all system edits, including an approved prior authorization for the dates billed.

For claims with dates of service prior to March 1, 2007, the reimbursement rate certification will continue to be required, billing will continue to be submitted by mail, and the payment process will remain a manual process. The provider will be reimbursed at the daily rate noted on the certification.

Changes to the Prior Authorization Process

The PA process will change to reflect the reduced reimbursement rate. Attachments are no longer required. The following information will be required for PA for dates of service on March 1, 2007 and forward:

Initial Review

PA will continue to be required within 10 calendar days of admission to a TFC program. The CAFAS item numbers, FAPT assessment information, DSM-IV and list of services being provided to the recipient in the first 45 days of treatment will continue to be required for an initial review. The Reimbursement Rate Certification will no longer be required. KePRO will need to receive a clear description of

behaviors that support the moderate to severe impairment noted on the CAFAS.

Continued Stay Review

PA will be required prior to the end of the previously authorized period. PA's are to be submitted no more than 30 days prior to the end of the current authorization period. The most current 90-Day Progress report information, current DSM-IV, and the most current CAFAS item numbers (no older than 90 days of the requested start date) must be provided. The FAPT Assessment, Comprehensive Treatment and Service Plan, Progress Updates, and Reimbursement Rate Certification will no longer need to be submitted, but must be available in the recipient's medical record at the facility. The Reimbursement Rate Certification must be available for review for dates of service prior to March 1, 2007.

The provider must certify in the submitted documentation and the clinical record that services at this level of care are necessary to address the on-going needs of the child or to prevent regression. The CAFAS must also be kept in the provider's record, and current, at a minimum of every 90 days.

Retroactive Authorization due to Retroactive Recipient Medicaid Eligibility or Late Requests

If a recipient is in placement for more than 45 days at the time of an initial PA request, the provider must submit to KePRO both the Initial Review requirements and the Continued Stay review requirements.

PA Authorizations – Old and New

Current authorizations that extend past February 28, 2007 will be end dated by DMAS with a date of February 28, 2007. The dates already approved or denied beginning March 1, 2007 will be carried over to a new PA number. The PAs already in effect with dates of service after February 28, 2007 (for which a new PA number will be generated) will be extended to the end of the last month of the current authorization. For example, a provider has an authorization for dates of service January 10, 2007 through July 10, 2007. The current authorization will be end-dated February 28, 2007. A new PA will be established for dates of service March 1, 2007 through July 31, 2007. Providers will receive notification of changes to PAs that are end-dated, and will receive their new PA numbers by letters generated through First Health Services. This is expected to be completed by March 1, 2007. The dates prior to March 1, 2007 will be paid at the daily rate; dates of March 1, 2007 and forward, will be paid at the new monthly rate of $326.50.

Beginning March 1, 2007, authorizations will be approved for up to a one year period. The only reason a PA will be approved for a shorter period of time will be at the provider's request, if the discharge date indicates a shorter stay, or if there is some other indication in the record submitted that a shorter stay is planned. Denials will continue to be for a two month period to facilitate completion of the appeal process and to facilitate a new request in the future if the service is again needed.

If a recipient is discharged during an authorized period after February 28, 2007, continue to notify KePRO of the discharge date. If an approval is for a full month, but the discharge date is mid-month, KePRO will not change the authorization for that month, only for subsequent months, since only one unit is authorized for each month, and only one provider can bill for that unit. If a new provider begins service mid-month, and the previous provider already has authorization for the month, the new provider's authorization will begin on the first of the next month. For example, provider A has an authorization for March 1, 2007 through December 31, 2007 for 10 units, and notifies KePRO of discharge on April 18, 2007. KePRO will reject the dates of service beginning 5-1-07 through 12-31-

07. Provider B submits a request for dates of service April 19, 2007 forward. KePRO may approve dates of service 5-1-07 forward. Provider B will not receive authorization for April 19, 2007 through April 30, 2007, since provider A already has an authorization for the one unit available for the month of April.

Timely Filing Requirements

For PAs with end-dates of February 28, 2007, DMAS is relaxing the timeliness requirement for submission of continued stay reviews. Providers have until April 1, 2007 to submit requests for continued stay reviews for clients who currently have authorization with an end date of February 28, 2007. Starting April 2, 2007, timely submission for request will again be applied and determinations will be made based on timeliness.

Alternate Methods to Obtain PA, Eligibility and Claims Status Information

DMAS offers a new, enhanced web-based Internet option (ARS) to access information regarding Medicaid or FAMIS eligibility, claims status, check status, service limits, prior authorization, and pharmacy prescriber identification. Current and new users of the ARS are required to migrate to the

new web-based ARS to logon and register prior to May 22, 2007. Please see the Medicaid Memo dated 1/19/2007 for more information. The website address to use to enroll for access to this system is http://virginia.fhsc.com. The MediCall voice response system will provide the same information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider. Providers may also access prior authorization information including status via iEXCHANGE at http://dmas.kepro.org/.

COPIES OF MANUALS

DMAS publishes electronic and printable copies of its Provider Manuals and Medicaid Memoranda on the DMAS website at www.dmas.virginia.gov. Refer to the "DMAS Content Menu" column on the left-hand side of the DMAS web page for the "Provider Services" link, which takes you to the "Manuals, Memos and Communications" link. This link opens up a page that contains all of the various communications to providers, including Provider Manuals and Medicaid

Memoranda. The Internet is the most efficient means to receive and review current provider information. If you do not have access to the Internet or would like a paper copy of a manual, you can order it by contacting Commonwealth-Martin at 1-804-780-0076. A fee will be charged for the printing and mailing of the manuals and manual updates that are requested.

PROVIDER E-NEWSLETTER SIGN-UP

DMAS is pleased to inform providers about the creation of a new Provider E-Newsletter. The intent of this electronic newsletter is to inform, communicate, and share important program information with providers. Covered topics will include changes in claims processing, common problems with billing, new programs or changes in existing programs, and other information that may directly affect providers. If you would like to receive the electronic newsletter, please sign up at: www.dmas.virginia.gov/pr-provider_newsletter.asp.

Please note that the Provider E-Newsletter is not intended to take the place of Medicaid Memos, Medicaid Provider Manuals, or any other official correspondence from DMAS.